



Department of Medical Assistance Services
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MEDICAID MEMO

TO: All Home and Community Based Care Waiver Service
Providers and Managed Care Organizations
Participating in the Virginia Medical Assistance
Programs

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

DATE: 10/23/2006

SUBJECT: Updates and Clarification of the Prior Authorization Process for Community Based
Care Services

The purpose of this memorandum is to provide periodic updates and clarification for the prior authorization (PA) process with Virginia Medicaid's PA contractor, Keystone Peer Review Organization (KePRO). This memorandum is one in a series of updates that will assist providers in obtaining PA-related information that will expedite the review process. We understand that some providers still are experiencing delays, however, we are seeing progress in the correct submission of Prior Authorizations by providers and in the number of PAs being processed by KePRO. We appreciate the provider input and suggestions given to us which have helped facilitate a greater understanding of providers' needs. We ask for your patience and understanding during this transition as we continue to improve upon the current process.

Timely Filing Requirements

DMAS has extended the relaxed requirement of timely submission for PA requests through December 31, 2006. This applies for request dates beginning June 19, 2006 (at the time of the KePRO implementation for waivers). **Starting January 1, 2007, timely submission for requests will again be applied and determinations will be made based on timeliness.**

Submitting Additional Information on an Open Case

Providers may submit additional information through iEXCHANGE by choosing "add to comments." (NOTE: The "extend case" feature is to be used when requesting additional days of coverage).

- Whenever a provider adds to comments, this puts the case back in the nurse review queue.
- If providers fax or phone in their PA request, you may receive a notice from KePRO for requesting additional information. Providers should submit additional information by following the instructions received from KePRO on the "fax-back" notice.

- If you receive a fax back form for error correction, please make the correction and **fax** back the form to the fax number at the top of the form. It is preferred to fax back the information requested for quicker processing.

Procedure Codes

The maximum number of procedure codes or services that can be submitted per PA is 18 (this is not a change).

- Any PA request having over 18 lines must be submitted via a separate PA request.
- For PA requests having more than 6 lines and submitted through iExchange, lines 6-18 must be listed in the “*additional comments*” section.
- Please include any required pricing and medical justification for all Assistive Technology or Environmental Modification requests.

Helpful Submission Tips for Quickest Processing

- Be aware of the recipient’s anniversary date and submit requests that do not cross over this date in to the next anniversary year. This applies to IFDDS waiver services (Respite requests are authorized on a calendar year for all waivers).
- Please include the diagnostic code in locator 10 on the DMAS-98 (Community Based Care Request for Services form).
- Be sure to provide necessary information to justify and correspond to the amount of service being requested.
- When submitting a request for a transfer, include the last date of service from the previous provider. The last date of service is the last day hands-on care was provided to the recipient.
- When requesting more than one service within the same request, please provide provider numbers for each servicing provider. Include requested dates of service and amount of services for each provider.
- Behaviors and symptoms need to be included in the request. Reference if these behaviors/symptoms are current or past concerns.
- Please do not send attachments with the DMAS-98 (Community Based Care Request for Services form) if you are requesting a service to an individual already enrolled, it will slow down processing of the request. All pertinent information must be documented on the DMAS-98.
- **When submitting a request for enrollment to a waiver, please submit the entire screening packet.** For first time enrollments in the waiver check “new request” in locator 1

at the top of the DMAS-98. Resubmitting a request after receiving a reject would be an initial request also.

- Please review the waiver manuals regarding documents that are necessary to submit to the PA contractor for waiver enrollments.
- Please use the DMAS-98 (Community Based Care Request for Services form) for all waiver enrollments and service requests. Additional detailed instructions on how to complete a request for waiver enrollment and services are found in the instructions to the DMAS-98.
- KePRO is unable to alter any information submitted on PA requests. Providers are responsible for providing accurate and correct information on their PA requests.

Additional Information for Providers

The following is more general information for you to know to help expedite processing of your requests.

- KePRO has begun faxing back notices of determinations for approvals, rejections, or denials.
- Rejects may be either a system reject or an administrative reject. *System rejects* occur when specific information is missing from the initial request. The fax back notice will indicate what missing information is being requested from the provider. The information being requested must be submitted to KePRO to complete the processing of your request. *Administrative rejects* occur when demographic information is incorrect, such as the recipient's identification number is missing or incorrect, or when the servicing provider identification number is incorrect. An administrative reject requires you to resubmit your entire request.
- On the fax back notice to the provider or in iExchange, if there is a PA number listed, please check the decision status for either approval, denial, or reject. Only PA numbers with an approved status are valid for claim processing purposes.

Resource Information

- Detailed instructions specific to submitting Waiver requests are found within the DMAS-98 (Community Based Care Request for Services Form). This form is located under "forms" on KePRO's website <http://dmas.kepro.org> or at www.dmas.virginia.gov/prior_authorization.htm.
- Should you have any questions regarding the prior authorization process, please send your inquiries via e-mail to providerissues@kepro.org or PAUR06@dmas.virginia.gov. Remember do not send PHI by e-mail unless it is sent via a secure encrypted e-mail submission.
- All other Medicaid provider issues not related to prior authorization should be addressed through the Provider Helpline. The numbers are 1-800-552-8627 or if you are located in Richmond or out-of-state call 804-786-6273.

KePRO Contact Information

You may contact KePRO through the following methods:

iEXCHANGE: <http://dmas.kepro.org/>

Toll Free Phone: 1-888-VAPAUTH (1-888-827-2884)

Local Phone: (804) 622-8900

Fax: 1-877-OKBYFAX (1-877-652-9329)

Mail: 2810 N. Parham Road, Suite 305,
Richmond, VA 23294

Provider Issues: ProviderIssues@kepro.org

DMAS and KePRO Website Resources

The following resources are available on the DMAS and KePRO websites:

1. iExchange Registration information
2. ICD9 diagnosis codes, outpatient rehab and home health revenue codes, and radiological scan procedure codes
3. Recent PA provider training presentations
4. Prior Medicaid Memos
5. PA Fax Request Forms and Instructions
6. PA Reference Guides

Alternate Methods to Obtain PA, Eligibility and Claims Status Information

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. To enroll for access to this system, go to <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access prior authorization information including status via iEXCHANGE at <http://dmas.kepro.org/>.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the “DMAS Content Menu” column on the left-hand side of the DMAS web page for the “Provider Services” link, which takes you to the “Manuals, Memos and Communications” link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at: www.dmas.virginia.gov/pr-provider_newletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

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